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| **Cibola General Hospital**<br>**1016 E. Roosevelt Ave.**<br>**Grants, NM 87020**<br>**Phone: 505-287-4446 Fax: 505-287-5309** | **Policy: 903088** | |
| **Title: Financial Assistance, Charity Care, Self-Pay & Payment Plan Policy** | | |
| **Policy First Effective: 12/18/2013** | **Revised: 06/2026** | **Last Reviewed: 06/26** |

# I. PURPOSE

To establish the standards governing patient financial assistance, charity care, uninsured discounts, payment arrangements, and limited self-pay account treatment for Cibola General Hospital Corporation (CGHC), and to ensure eligible patients have access to emergency and other medically necessary services regardless of ability to pay.

CGHC will provide emergency medical screening examinations and any necessary stabilizing treatment in accordance with EMTALA, regardless of a patient's insurance status, financial status, or eligibility for financial assistance.

This policy also establishes the framework for consistent review of patient financial need, the application of eligible discounts and payment arrangements, and the administration of related billing practices, in accordance with applicable law and organizational requirements.

This policy integrates:

- Charity Care
- Financial Assistance Discounts
- Patient Payment Plans
- Breast and Cervical Program
- Mammo Fund
- Emergency Medicaid Applications
- Self Pay- Financial Counseling assistance (0-31 Days in AR)
    - Prompt Payment Discounts
    - Payment Arrangements

  Program Screening

# II. SCOPE

This policy applies to the following CGHC entities, as applicable:

- Cibola General Hospital (CGH)
- Cibola Family Health Center (CFHC)
- Cibola Specialty Associates (CSA)
- Cibola Behavioral Health and Wellness (CBHW)

This policy applies to uninsured patient services such as emergency services, medically necessary inpatient services, and medically necessary outpatient services furnished by CGHC

entities, except where a particular assistance program, funding source, or operational process is limited to a specific entity, service line, or patient population.

Professional services billed separately by independent practitioners or other non-CGHC entities are not governed by this policy unless expressly stated.

## III. POLICY STATEMENT

CGHC will:

- Provide emergency medical screening examinations and stabilizing treatment in accordance with EMTALA, without regard to ability to pay
- Offer financial assistance to eligible patients for emergency and other medically necessary services in accordance with this policy
- Not discriminate on the basis of protected characteristics in the application of this policy
- Limit charges for eligible patients in accordance with applicable law, including the requirement that FAP-eligible patients not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care
- Offer payment arrangements, when appropriate, based on a patient's financial circumstances and this policy
- Administer billing and collection practices in a fair, consistent, and compliant manner

Eligibility for assistance under this policy will be determined based on applicable program criteria, including income, household size, available resources, financial hardship, and other relevant circumstances documented during the review process.

## IV. DEFINITIONS

- **Charity Care:** A full write-off of eligible guarantors "responsible party" that meets Charity application criteria.
- **Emergency Services:** Emergency medical screening examinations and any related stabilizing treatment required under EMTALA.
- **Financial Assistance:** Full or partial reduction of eligible patient charges under this policy based on financial applicable criteria met for programs listed in section I.
- **Gross Income:** Total household income from all countable sources before deductions, unless otherwise specified in this policy or required by law.
- **Household:** The patient and any individual counted as part of the patient's household for purposes of financial assistance review under this policy.
- **Liquid Assets:** Cash and other resources readily convertible to cash, excluding assets that are protected or excluded under applicable policy or law.
- **Medically Necessary Care: As defined by NM Medicaid for EMSA "Emergency Medicaid Assistance Application.** Non-elective services that are reasonably required to prevent, diagnose, correct, cure, alleviate, or prevent worsening of a condition that endangers life.
- **Payment Plan:** An approved arrangement that allows an eligible guarantor to pay an outstanding balance over time under terms established by CGHC.
- **Self-Pay:** A guarantor who is uninsured, or who qualifies as self-pay under applicable law and CGHC policy for a particular non-emergent service**.**

- **Underinsured:** A guarantor or subscriber with "out of network payors" active coverage whose insurance does not fully cover medically necessary services and who may still qualify for assistance under this policy based on financial need and other criteria.

## V. ELIGIBILITY CRITERIA

Patients may be considered for financial assistance under this policy when they receive emergency or other medically necessary services from CGHC and demonstrate financial need based on the criteria set forth in this policy.

Eligibility may be considered for patients who are:

- Uninsured
- Underinsured – Out of Network Payors
- Insured but experiencing financial hardship related to eligible medically necessary services
- Unable to pay for eligible services due to income, household resources, or documented special circumstances for non-elective services. Elective, cosmetic, convenience, or other non-medically necessary services are not eligible unless specifically approved by CGHC.

Financial assistance under this policy generally applies only to emergency services and other medically necessary services furnished by CGHC.

The Guarantor may be required to cooperate in identifying and applying for available sources of coverage or assistance, including Medicaid or other governmental or third-party programs, when applicable. Failure to respond with timely requests such screening appointments or application requirements may result in denial of financial assistance unless an exception is approved based on documented circumstances.

Eligibility determinations include household income, household size, liquid assets, disposable income and other documentation relevant to the ~~patient's~~ guarantor ability to pay.

## VI. FINANCIAL ASSISTANCE DETERMINATION

CGHC will evaluate financial assistance applications using a dual methodology that includes:

1. A review of household income in relation to the Federal Poverty Level (FPL), and
2. A review of disposable income and other documented financial hardship factors when FPL alone does not fully reflect the guarantors ability to pay.
   FPL will serve as the primary screening tool. Disposable income and hardship review may be used to support, increase, or otherwise adjust the assistance determination when justified by the guarantors documented financial circumstances.

### A. Federal Poverty Level Review

CGHC will use the current Federal Poverty Guidelines in effect at the time of review, based on household size and annual household income.

Unless otherwise approved on an exception basis, the following general assistance levels apply:

- **At or below 200% of FPL:** Eligible for up to 100% charity care

- **201% to 250% of FPL:** Eligible for up to 75% financial assistance
- **251% to 300% of FPL:** Eligible for up to 50% financial assistance
- **301% to 400% of FPL:** Eligible for up to 25% financial assistance
- **Above 400% of FPL:** Generally not eligible for standard financial assistance, but may be considered for a payment plan or exception review based on documented hardship

CGHC may maintain current FPL reference tables administratively rather than reproducing the full annual table within this policy.

**B. Disposable Income / Hardship Review**
When FPL alone does not adequately reflect the patient's financial circumstances, CGHC may also review disposable income and documented hardship.

Disposable income generally will be calculated as:
Gross Monthly Household Income minus Essential Monthly Living Expenses = Disposable Income

Essential living expenses may include reasonable amounts for:
- Housing
- Utilities
- Food
- Transportation
- Insurance
- Childcare
- Medication or other necessary medical expenses
- Other documented essential expenses approved by CGHC
  Unless otherwise approved on an exception basis, the following general hardship guidance may be used:
- **Disposable income at or below $0:** Eligible for up to 100% charity care
- **Disposable income of $1 to $200:** May support up to 75% to 100% financial assistance
- **Disposable income of $201 to $500:** May support up to 50% to 75% financial assistance
- **Disposable income above $500:** Generally not eligible for additional hardship-based discount, but may be considered for a payment plan or exception review

**C. Supporting Documentation**
CGHC may require documentation reasonably necessary to evaluate eligibility, including but not limited to:
- Pay stubs
- W-2 forms
- Tax returns
- Bank statements
- Proof of public benefits or denial of benefits
- Documentation of household expenses
- Documentation of extraordinary medical or financial hardship

If standard documentation is unavailable, CGHC may accept alternate documentation or a patient attestation when appropriate, based on the circumstances.

**D. Final Determination**
Financial assistance determinations will be made based on the totality of the information available to CGHC, including FPL, disposable income, household resources, documented hardship, and any applicable exception review.

CGHC reserves the right to approve, deny, or adjust assistance levels based on incomplete information, conflicting information, failure to cooperate in the review process, or documented special circumstances.

## VII. APPLICATION PROCESS (FINANCIAL ASSISTANCE)

Guarantor may request financial assistance up to 31 days after the time of service.

Applications for financial assistance may be submitted by the guarantor, a legally authorized representative, Medical Power of Attorney or Parent of Guarantor up to legal age of minor under NM law

**A. How to Apply**
CGHC will make financial assistance applications available through appropriate patient access points, which may include registration areas, billing communications, the CGHC website, and patient financial services.

Patients seeking assistance may be asked to complete a financial assistance application and provide supporting documentation reasonably necessary to evaluate eligibility.

**B. Supporting Documentation**
Documentation may include, as applicable:

- Pay stubs
- W-2 forms
- Federal income tax returns
- Bank statements
- Proof of public benefits or denial of benefits
- Documentation of household expenses
- Documentation of medical hardship or other special circumstances

If a patient is unable to provide standard documentation, CGHC may accept alternate documentation or a written patient attestation when appropriate based on the circumstances.

**C. Incomplete Applications**
If an application is incomplete, CGHC will make reasonable efforts to notify the patient of the missing information needed to complete the review.

When required by applicable law or policy, the patient will be given a reasonable opportunity to provide the missing information before a final adverse determination is made or before any extraordinary collection action is initiated.

**D. Review Process**
CGHC will review completed applications within a reasonable time after receipt of all information needed to make a determination. As a general guideline, CGHC will attempt to issue a determination within 10 business days of receiving a substantially complete application, although additional time may be required in complex cases or when follow-up information is needed.

**E. Notice of Determination**
Patients will be notified of the determination in writing or by another documented method approved by CGHC. The notice will generally include whether the application was approved, denied, or approved in part, and may include the level of assistance granted, any remaining patient responsibility, and any payment plan options offered.

**F. Effective Period of Approval**
Financial assistance will be backdated 90 days from the date of approval for NM Medicaid if guarantor meets NM Medicaid Income and HH criteria. Charity approval will be based on current income and household guidelines.

**G. Duty to Provide Accurate Information**
Patients are responsible for providing information that is true, complete, and not misleading to the best of their knowledge. CGHC may deny, modify, or revoke financial assistance if the information provided is materially incomplete, inaccurate, inconsistent, or fraudulent.

## VIII. PATIENT PAYMENT PLAN POLICY

**A. General Standards**
CGHC may offer payment plans to eligible patients to promote access, support patient financial responsibility, and reduce unnecessary collection activity, while maintaining consistent, compliant account management practices.

**B. General Eligibility**
Payment plans may be offered for eligible patient balances when the patient is unable to pay the balance in full, and:

- Demonstrates financial need or hardship
- Does not qualify for full charity care
- Has remaining patient responsibility after financial assistance or uninsured discount adjustments
- Requests a payment arrangement and agrees to comply with the approved terms

Approval of a payment plan is subject to CGHC review and is not guaranteed in all circumstances.

**C. Standard Payment Plan Terms**

CGHC will generally seek to structure payment plans so that eligible balances are resolved within **12 months**. Standard plan terms may vary based on account balance, prior payment history, financial circumstances, and administrative criteria established by CGHC.

Longer repayment periods may be approved on an exception basis when supported by documented hardship or other appropriate circumstances.

**D. Minimum Payment Expectations**
CGHC may establish minimum installment expectations or other administrative payment plan criteria to support consistent account management. Such criteria may be maintained administratively and updated from time to time without requiring formal policy revision. Requests for payment terms below the standard administrative thresholds may require additional review and approval by the Chief Financial Officer (CFO) or designee.

**E. Consolidation of Accounts**
When appropriate, CGHC may consolidate multiple eligible patient balances into a single payment arrangement for ease of administration and patient convenience. Consolidation may be limited based on the nature of the accounts, entity-specific workflows, or other operational considerations.

**F. Approval Authority and Exceptions**
The CFO or designee may approve exceptions to standard payment plan terms, including:

- Reduced installment amounts
- Extended repayment periods
- Other payment arrangements supported by documented hardship or special circumstances

Documentation supporting the exception should be maintained in the account record or other designated administrative file.

**G. Missed Payments and Plan Default**
CGHC may allow a reasonable grace period for late payments under an approved payment plan. Failure to make payments as agreed, or failure to communicate with CGHC regarding payment difficulties, may result in default of the payment plan and return of the account to standard billing or collection processes, subject to applicable law and CGHC policy.
Nothing in this section authorizes extraordinary collection actions unless and until all applicable legal and policy requirements have been satisfied.

**H. Application and Review Process**
A patient requesting a payment plan may be required to complete a financial assistance application or provide financial information reasonably necessary to evaluate the request. CGHC will generally review payment plan requests within a reasonable time and, when practicable, within **10 business days** after receiving sufficient information to evaluate the request.

Patients will be notified of the approved payment terms or other determination using a documented communication method.

## IX. Self-Pay Patients and Uninsured Discounts

Cibola General Hospital (CGH) may offer self-pay pricing and uninsured patient discounts for individuals who do not have health insurance coverage or another available third-party payment source.

Self-pay pricing, uninsured discounts, payment requirements, eligibility criteria, documentation requirements, and operational procedures shall be administered in accordance with CGH's Self-Pay Discount and Payment Procedures and any applicable federal and state laws.

Patients with active insurance coverage are generally expected to utilize available insurance benefits unless otherwise permitted by applicable law, payer contract, or approved organizational policy.

Nothing in this policy authorizes CGH to forgo submission of claims when billing is required by law, regulation, governmental program requirements, or contractual obligations.

Patients who may qualify for Financial Assistance under this policy will be evaluated in accordance with the Financial Assistance provisions contained herein. When multiple assistance programs or discounts are available, CGH will apply the most favorable adjustment permitted under applicable law and organizational policy.

CGH reserves the right to request documentation necessary to verify uninsured status, determine the availability of third-party coverage, and administer self-pay pricing in accordance with organizational procedures.

## X. Patient Request to Self-Pay for Non-Emergent Services

Cibola General Hospital (CGH) recognizes that, in limited circumstances, a patient with active insurance coverage may request to be treated as self-pay for a non-emergent service rather than have a claim submitted to available insurance.

Such requests are not routinely granted and may be considered only when permitted by applicable law, governmental program requirements, payer contract provisions, and CGH policy.

CGH will not encourage, direct, or steer patients to forgo available insurance coverage. Any request to be treated as self-pay must originate from the patient or the patient's legally authorized representative.

Requests for self-pay treatment of insured accounts shall be reviewed and administered in accordance with CGH's Self-Pay Election Procedure and any applicable legal, regulatory, contractual, and compliance requirements.

This section does not apply to emergency medical conditions, emergency medical screening examinations, or stabilizing treatment governed by EMTALA.

CGH reserves the right to approve, deny, or revoke any self-pay election request when required by law, payer contract obligations, governmental program requirements, operational considerations, or organizational policy.

Patients approved for self-pay treatment under this section may be required to execute forms, acknowledgments, and other documentation as determined necessary by CGH. Pricing, discounts, payment requirements, and account administration for approved requests shall be governed by applicable CGH procedures.

Documentation supporting the request and any resulting determination shall be maintained in accordance with CGH record retention and documentation requirements.

## XI. Good Faith Estimates for Uninsured or Self-Pay Patients

CGHC will provide a Good Faith Estimate of expected charges to uninsured or self-pay individuals, or their authorized representative, as required by applicable law.

For purposes of this section, a self-pay individual may include a patient who does not have health insurance coverage for the item or service, or a patient who does not plan to use available insurance coverage for an item or service, when treated as self-pay in accordance with this policy and applicable law.

A good faith estimate under this section is not a bill and is based on information reasonably available at the time the estimate is issued. Actual charges may differ if additional or unexpected items or services are medically necessary or otherwise arise during the course of care.

CGHC will provide good faith estimates within the timeframes required by applicable law for scheduled items or services and upon request, using the format and content required by law and applicable CMS guidance.

Nothing in this section alters CGHC's obligations under EMTALA and this section shall not be applied in a manner that delays emergency medical screening examinations or stabilizing treatment.

Patients who receive a good faith estimate may have rights under the federal patient-provider dispute resolution process if the final billed charges from a provider or facility are at least $400 higher than the good faith estimate for that provider or facility, as provided by applicable law.

CGHC may maintain detailed operational procedures, notice content, and workflow requirements for good faith estimates outside of this policy.

## XII. PATIENT NOTIFICATION AND PUBLICITY

CGHC will make information about financial assistance, uninsured self-pay discounts, payment arrangements, and related patient financial help available in a manner reasonably calculated to inform patients, guarantors, and members of the community served by CGHC.

At a minimum, CGHC will publicize the Financial Assistance Program and related application process through appropriate methods, which may include:

- The CGHC website
- Paper copies available upon request and without charge in appropriate public locations
- Registration, admissions, emergency department, billing, or patient financial services areas, as applicable
- Billing statements or billing communications, as required or appropriate
- Signage, brochures, or other written materials designed to alert patients and visitors to the availability of financial assistance
- Staff communication or referral to Patient Financial Services, when appropriate

CGHC will make available, in accordance with applicable law, the financial assistance policy, the financial assistance application form, and a plain language summary of the Financial Assistance Program.

CGHC will provide information about the availability of financial assistance and how to apply in a manner reasonably calculated to reach patients and community members who are most likely to require such assistance.

When required by applicable law or operational need, CGHC may provide translated materials, interpreter support, or other language access measures to support meaningful access to financial assistance information and the application process. IRS materials also contemplate translation of the FAP, application, and plain language summary for limited-English-proficiency populations when applicable.

CGHC may maintain detailed notice formats, posting locations, statement language, and workflow requirements outside of this policy, provided such practices remain consistent with applicable law and this policy.

## XIII. COLLECTION PRACTICES

CGHC will administer billing and collection practices in a fair, consistent, and compliant manner that supports patient access and complies with applicable law.

CGHC may engage in ordinary billing and collection activity, including issuance of bills, follow-up statements, phone calls, payment plan discussions, financial assistance screening, referral to internal account follow-up, and other routine collection efforts permitted by law and organizational policy.

CGHC will make reasonable efforts to determine whether an individual is eligible for financial assistance under this policy before engaging in any extraordinary collection action (ECA) related to amounts owed for emergency or other medically necessary care.

**A. Extraordinary Collection Actions**
For purposes of this policy, extraordinary collection actions may include actions such as:

- Selling an individual's debt to another party
- Reporting adverse information to consumer credit reporting agencies or credit bureaus
- Deferring, denying, or requiring payment before providing medically necessary care because of nonpayment of prior bills
- Legal or judicial actions, including liens, garnishments, civil actions, or similar processes permitted by law

CGHC will not initiate, and will not permit a third party acting on its behalf to initiate, any extraordinary collection action unless all applicable legal and policy requirements have been satisfied.

**B. Reasonable Efforts Before Extraordinary Collection Actions**
Before taking any extraordinary collection action, CGHC will make reasonable efforts to determine whether the individual is eligible for financial assistance under this policy.

Reasonable efforts may include, as applicable:

- Providing notice of the availability of financial assistance
- Giving the patient or responsible party an opportunity to apply for financial assistance
- Reviewing any complete or substantially complete financial assistance application submitted
- Providing notice of missing information needed to complete an incomplete application, when applicable
- Offering or discussing payment arrangements when appropriate
- Delaying extraordinary collection actions until the financial assistance review process and any required notice periods have been completed, as required by law and policy

**C. Third-Party Collection Activity**
Any collection agency, debt buyer, law firm, or other third party acting on behalf of CGHC, or receiving accounts from CGHC, must comply with applicable law, this policy, and any contractual requirements established by CGHC.
CGHC remains responsible for overseeing billing and collection activity performed on its behalf and may require contractual safeguards, monitoring, corrective action, or account recall when necessary to maintain compliance. IRS states that a hospital facility is held accountable for ECAs of third parties collecting debt on its behalf or to which it sells debt.

**D. Reclassification or Adjustment of Accounts**
CGHC may reclassify, adjust, suspend, recall, or otherwise modify an account when:

- A patient is later found eligible for financial assistance
- Additional financial hardship information is received
- An account qualifies for charity care reclassification under this policy

- A billing or collection action must be corrected to comply with applicable law, contract requirements, or organizational policy

**E. Operational Procedures**
CGHC may maintain detailed billing, statement, notice, payment default, collection referral, and account review procedures outside of this policy, provided such procedures remain consistent with this policy and applicable law.

## F. Collections Escalation and Write-Off Process
CGHC maintains a structured, progressive collection process to ensure patients are provided reasonable opportunity to resolve balances while supporting timely and compliant revenue cycle management.

**1. Early-Out (Internal Collections) Phase**
**Timeframe:** Date of first patient statement through **120 days**
During this period, accounts remain under CGHC management or designated early-out vendor and may include:
- Initial billing and a minimum of three (4) patient statements
- Reasonable collection efforts, including phone calls and outreach
- Financial assistance screening and application opportunity
- Payment plan discussions and prompt-pay options

Accounts with active payment plans, pending financial assistance review, or demonstrated good faith effort may remain in Early-Out status beyond standard timeframes at CGHC discretion.

**2. Bad Debt (External Collections) Phase**
**Timeframe: 121–240 days** from first patient statement
Accounts that remain unpaid and without active engagement may be referred to an external collection agency.
During this phase:
- The account is classified as **Bad Debt**
- A final notice may be issued prior to referral
- Collection activity may include letters, phone outreach, and other lawful recovery efforts
- Reporting to credit agencies may occur in accordance with applicable law

CGHC will ensure reasonable efforts to determine Financial Assistance eligibility have been made prior to referral.

**3. Write-Off and Account Closure**
**Timeframe: ≥ 241 days** from first patient statement
Accounts may be considered for write-off when:
- Reasonable collection efforts have been exhausted
- No payment activity or patient engagement has occurred
- The account has completed the Bad Debt collection cycle

Write-offs may include:
- Bad Debt Write-Off
- Charity Care Adjustment (if retroactively qualified)
- Administrative Adjustment (e.g., deceased, bankruptcy, small balance)

All write-offs must be:

- Approved in accordance with CGHC financial authorization thresholds
- Documented with supporting rationale
- Applied consistently and in compliance with applicable law

**4. Exceptions and Special Circumstances**
CGHC may adjust or suspend the escalation process in situations including:

- Active payment plans in good standing
- Pending or approved financial assistance applications
- Deceased patient accounts
- Bankruptcy or legal holds
- Disputed or under-review accounts

**5. Administrative Flexibility**
CGHC may maintain detailed operational timelines, vendor workflows, and escalation criteria administratively, provided such processes remain consistent with this policy and applicable law.

## XIV. EMTALA COMPLIANCE

Nothing in this policy shall be applied in a manner that delays, interferes with, or conditions the provision of an appropriate medical screening examination or any necessary stabilizing treatment required under EMTALA.

CGHC will provide emergency medical screening examinations and any necessary stabilizing treatment in accordance with EMTALA, regardless of a patient's insurance status, financial status, ability to pay, or eligibility for financial assistance. Financial discussions, payment arrangements, and financial assistance screening must not delay or interfere with EMTALA-required care.

## XV. RECORD KEEPING

CGHC will maintain records sufficient to document compliance with this policy, applicable law, and related operational requirements.

Records maintained under this section may include, as applicable:

- Financial assistance applications
- Supporting documentation submitted by the patient or accepted by CGHC
- Determinations, approvals, denials, and partial approvals
- Documentation of exception reviews or hardship-based adjustments
- Payment plan approvals and related account documentation
- Self-pay discount determinations
- Approved insured self-pay request acknowledgments under Section X
- Charity care write-offs or account reclassifications
- Billing, notice, and collection documentation maintained in the ordinary course of business

- Other records necessary to demonstrate compliance with this policy and applicable legal requirements

Records will be maintained in accordance with CGHC's record retention practices and any applicable legal, regulatory, financial, and operational requirements.

## XVI. REFERENCES

- Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd
- 42 C.F.R. § 489.24, Special responsibilities of Medicare hospitals in emergency cases
- Internal Revenue Code Section 501(r)
- 26 C.F.R. §§ 1.501(r)-1 through 1.501(r)-7
- IRS, Financial Assistance Policy and Emergency Medical Care Policy, Section 501(r)(4) (irs.gov)
- IRS, Billing and Collections, Section 501(r)(6) (irs.gov)
- No Surprises Act and applicable federal Good Faith Estimate requirements for uninsured or self-pay individuals, including CMS guidance (cms.gov)
- CMS guidance regarding the Medicare Advance Beneficiary Notice of Noncoverage (ABN), as applicable to Medicare Fee-for-Service items and services (cms.gov)